

70



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert C. E. Albright</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 15 1980		2b. DATE OF DEATH MONTH DAY YEAR 9 15 1980	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR 8 21 21	6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 15 1980		7d. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b> MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hampstead</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1435 Fairmount Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;D</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1435 Fairmount Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Albright</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lilie Shorb</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW2 Army</b>		17. INFORMANT <b>Mrs. Mary Albright, Hampstead, Md.</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia, Secondary to Myocardial Ischemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Previous Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis, Coronary Arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held in death resulted from Natural causes <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Robert C. E. Albright</i>		M.D. <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <b>17 Sept 80</b>			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-18-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Jacob's (Stone) Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brodbecks York Pa.</b>			
24. FUNERAL DIRECTOR <b>Elaine Funeral Home, Hampstead, Md. 21074</b>						25. DATE RECEIVED BY REGISTRAR <b>SEP 24 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial request permit. Then please remove cardholders, Pages 1 and 2, and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CLarence Edward BAKER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Sept 2 1980</b>			2b HOUR <b>1215 P</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept 30 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a BIRTHPLACE (COUNTRY) <b>Balto Co.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD	
10 CITY OR TOWN OF DEATH <b>Manchester</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Long View Nursing Home Inc</b>		12a USUAL OCCUPATION (STATE OF WORK FOR MOST OF WORKING LIFE) <b>Railroad Conductor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Fenn Railroad</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>		13b CITY OR TOWN <b>Baltimore</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>3150 Remington Ave</b>	
14 FATHER'S NAME FIRST <b>William</b> MIDDLE <b>J</b> LAST <b>Baker</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Beil</b> MIDDLE <b>Cross</b> LAST <b>Cross</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO <b>417 07 8009</b>		17 INFORMANT ADDRESS <b>Long View Nurs. Home Record, Manchester Md</b>			
18 CAUSE OF DEATH (Enter only one cause per line, and state the date of onset of the condition.)							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>							
436- } DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
b) <b>Cerebral arteriosclerosis</b> <b>5 yrs</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>arteriosclerotic Heart Disease</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>611 P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from <b>611</b> 19 <b>77</b> to <b>Sept 2</b> 19 <b>80</b> that (we) last saw the deceased alive on <b>9/2/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>W. H. Foard MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/2/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>W H Foard MD</b>		22e ADDRESS <b>3223 Main St Manchester, Md 21102</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>5 Sept. 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Rayville, Balto. Co. Maryland</b>	
24 FUNERAL DIRECTOR <b>Burgee Funeral Home 3631 Falls Rd. 21211</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 3 1980</b>		25b REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 3 3 5 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Margaret E. Heagy Beard

2a. DATE OF DEATH

MONTH

DAY

YEAR

9 11 80

2b. HOUR

19 25

M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

10- 28- 1898

6. AGE (IN YEARS LAST BIRTHDAY)

81

7. IF UNDER 1 YEAR

MONTHS

DAYS

8. IF OVER 1 YEAR

HOURS

MIN

9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md.

10. CITIZEN OF WHAT COUNTRY?

U.S.A.

11. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

12. BALTIMORE CITY OR COUNTY OF DEATH

Carroll

MD

13. CITY OR TOWN OF DEATH

Westminster

14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Carroll Co. General

15a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Checker

15b. KIND OF BUSINESS OR INDUSTRY

Canning

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Carroll

13c. CITY OR TOWN

Westminster

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

93 Timber Ridge Drive

16. FATHER'S NAME

FIRST

MIDDLE

LAST

William Edward Heagy

17. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

E. Kate Gardner

18a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

18b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

None

18c. INFORMANT

215-18-1118

18d. ADDRESS

George W. Beard Westminster, Md.

19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIOGENIC SHOCK

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Days

4140

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

CONGESTIVE HEART FAILURE

Days

DUE TO, OR AS A CONSEQUENCE OF

(c)

ARTERIO-SCLEROTIC HEART DISEASE

Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (1) (this hospital) attended the deceased from 8/30 19 80 to 9/11 19 80 that (1) (we) last  
saw the deceased alive on 9/11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I/we) (did) (did not) view the body after death.

22a. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

9/11/80

22b. PHYSICIAN'S NAME (TYPE OR PRINT)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

9/15/1980

23c. NAME OF CEMETERY OR CREMATORY

Deer Park

23d. LOCATION  
CITY OR TOWN

Westminster Carroll, Md

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Robert Kyle Pruitt Jr. Westminster, Md

25a. DATE REC'D. BY REGISTRAR

SEP 16 1980

25b. REGISTRAR'S SIGNATURE

[Signature]

COLLECTOR

1938



1938

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 3 3 5 4

1 DECEASED NAME (TYPE OR PRINT) <b>ELMER E. BOSLEY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>SEPT 14, 1980</b>			2b HOUR <b>6:30 A.M.</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4-26-1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7b HOUR <b>4 18</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>COUNTY - CARROLL MD.</b>				
10 CITY OR TOWN OF DEATH <b>MANCHESTER</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOME 2802 Park Ave</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MD. STATE ROADS</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>MARYLAND</b>			13b COUNTY <b>CARROLL</b>		13c CITY OR TOWN <b>MANCHESTER</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS E. BOSLEY</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ELIZABETH Bosley</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>214-20-0928</b>	
17 INFORMANT <b>Edith Farrell</b>			ADDRESS <b>2802 Park Ave Manchester, MD</b>			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE ATHEROSCLEROTIC DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRO-VASCULAR ACCIDENT</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS</b>										
19a DATE OF OPERATION <b>9/14/80</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 28, PART 3 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>12/8/78</b> 19 to <b>9/14/80</b> 19, that (I) (we) last saw the deceased alive on <b>9/17/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>S.D. Morjaria</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9-14-80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.D. MORJARIA</b>			22e ADDRESS <b>3125 MAIN ST. MANCHESTER 21102</b>							
23a BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>			23b DATE <b>Sept. 17, 1980</b>		23c NAME OF CEMETERY OR CREMATORIUM <b>ECKHERDT Zion</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Upperco, Baltimore Md</b>			
24 FUNERAL DIRECTOR <b>A. J. Schladt</b> ADDRESS <b>Manchester, MD</b>										

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





RECEIVED THE 11th 1908  
AT 11:15 AM  
JAN 11 1908

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AT 11:15 AM  
JAN 11 1908





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 5 5

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RICHARD (NMN) BOWMAN, Sr.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Sept 16, 1980</b>		2b HOUR <b>1240 M</b>	
3 SEX <b>MALE</b>		4 RACE <b>NEGRO</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 10, 1909</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		7 UNDER 1 YEAR MONTHS DAYS <b>2 6</b>		7 UNDER 74 HRS HOURS MIN <b></b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD</b>						
10 CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL COUNTY G.H.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>Farm</b>						
13a STATE <b>Maryland</b>		13b COUNTY <b>Carroll</b>		13c CITY OR TOWN <b>New Windsor</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>William H. Bowman</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Broughtus</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>213-24-7997A</b>		17 INFORMANT ADDRESS <b>Margaret A. Bowman, Same As #13</b>		
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Uremia</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>Sept 13, 1980</b> to <b>Sept 16, 1980</b> , that (I) (we) last saw the deceased alive on <b>Sept 16, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>John S. Harshey, MD</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>9/16/80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN S. HARSHEY, MD</b>		22e ADDRESS <b>Sancho St. Westminster, Md. 21157</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9-20-1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Western Chapel</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>Carroll, Md.</b>						
24 FUNERAL DIRECTOR NAME ADDRESS <b>Charles W. Burrier, Jr., Sykesville, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 19 1980</b>		25b REGISTRAR'S SIGNATURE <b>H. H. H. H.</b>		

MEDICAL CERTIFICATION

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper's Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



July 10, 1900

216

Carroll Co.,

U. S. A.

Lawrence

Postmaster

Editor

and

Carroll Law Library

Route 2 - Carroll

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-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-2567-2568-2569-2570-2571-2572-2573-2574-2575-2576-2577-2578-2579-2580-2581-2582-2583-2584-2585-2586-2587-2588-2589-2590-2591-2592-2593-2594-2595-2596-2597-2598-2599-2600-2601-2602-2603-2604-2605-2606-2607-2608-2609-2610-2611-2612-2613-2614-2615-2616-2617-2618-2619-2620-2621-2622-2623-2624-2625-2626-2627-2628-2629-2630-2631-2632-2633-2634-2635-2636-2637-2638-2639-2640-2641-2642-2643-2644-2645-2646-2647-2648-2649-2650-2651-2652-2653-2654-2655-2656-2657-2658-2659-2660-2661-2662-2663-2664-2665-2666-2667-2668-2669-2670-2671-2672-2673-2674-2675-2676-2677-2678-2679-2680-2681-2682-2683-2684-2685-2686-2687-2688-2689-2690-2691-2692-2693-2694-2695-2696-2697-2698-2699-2700-2701-2702-2703-2704-2705-2706-2707-2708-2709-2710-2711-2712-2713-2714-2715-2716-2717-2718-2719-2720-2721-2722-2723-2724-2725-2726-2727-2728

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>MARCELLO</b>			First Middle Lost			2a. DATE OF DEATH Month <b>9</b> - Day <b>20</b> - Year <b>80</b>			2b. HOUR <b>7:45 AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>8/15/1883</b>			6. AGE (In years lost birthday) <b>97</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>ITALY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>ITALY</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CARROLL</b> County Md.		
10. CITY OR TOWN OF DEATH <b>SYKESVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRINGFIELD HOSP. CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Balto, City</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>BALTO. CITY</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>917 STILES STREET</b>			14. FATHER'S NAME First Middle Lost <b>Nichola ? Branchiforte</b>			15. MOTHER'S MAIDEN NAME First Middle Lost <b>? Rose Tusconna</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-54-7710</b>			17. INFORMANT <b>Angelo Branchiforte</b>			Address <b>957 Thompson Blvd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration PNEUMONIA</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SENILITY + ARTERIOSCLEROSIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-17</b> , 19 <b>88</b> , to <b>9-20</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9-20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Elise J. Robinson M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>9/20/80</b>		
22d. PHYSICIAN'S NAME (Type) <b>ELISE J. ROBINSON</b>						22e. ADDRESS <b>SPRINGFIELD HOSPITAL CENTER RT 32 SYKES. MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9/24/80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md</b>		
24. FUNERAL DIRECTOR <b>Walter Dabrowski 1005 Dundalk Avenue</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 25 1980</b>			25b. REGISTRAR'S SIGNATURE <i>Richard Anthony</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days of death.

(M)

Nichols

Branchville

House

Township

Angelo Branchville 333 Thompson Blvd.

Butler 9/23/80 Holy Redeemer

Butler

Butler 9/23/80 Holy Redeemer

229 12 980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Oden Buckingham</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 26, 1980</b>		2b. HOUR <b>19 20 M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 2 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD	
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>business</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>New Windsor</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>223 Main St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jesse K. Buckingham</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Winters</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-01-8057</b>		17. INFORMANT ADDRESS <b>223 Main St. New Windsor, Md.</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Oat cell carcinoma, left lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 5, 19 80</b> to <b>Sept 26, 19 80</b> , that (I) (we) last saw the deceased alive on <b>Sept 26, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>John S. Harshey, MD</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN S. HARSHEY, MD.</b>		22e. ADDRESS <b>8 Anchor St. Westminster, Md. 21157</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/29/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>New Windsor Carroll Md.</b>	
24. FUNERAL DIRECTOR NAME <b>D. S. Hartzler</b>		ADDRESS <b>New Windsor, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 30 1980</b>	

(M)

SEP 9 1980

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 5 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE OLIVIA DAVIS			2a DATE OF DEATH MONTH DAY YEAR SEPTEMBER 12, 1980		2b HOUR M						
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR January 7, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD					
10 CITY OR TOWN OF DEATH Eldersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2312 Lake Circle Drive				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b KIND OF BUSINESS OR INDUSTRY Antique Shop			
13a STATE Maryland			13b COUNTY Carroll		13c CITY OR TOWN Eldersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 2312 Lake Circle Drive		
14 FATHER'S NAME FIRST MIDDLE LAST William Owens Welch						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aniah Virginia Hutchins					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO 217-05-9725			17 INFORMANT ADDRESS Mrs. Charlotte B. Davis Same					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO OR AS A CONSEQUENCE OF

(b)

DUE TO OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lastAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 WKS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 19 80, to 9/11/80, that (I) (we) last saw the deceased alive on 9/9/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Seymour Weiner		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/15/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Seymour Weiner, M.D.				22e ADDRESS 1900 E. Northern Parkway Balto., Md.			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept. 15, 1980		23c NAME OF CEMETERY OR CREMATORY Druid Ridge		23d LOCATION CITY OR TOWN COUNTY STATE Pikesville, Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Balto., Md.		25a DATE REC'D BY REGISTRAR (15 REGISTRATION SIGNATURE) SEP 17 1980			

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





SEP 1 1980

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 5 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Romaine J. Dell			2a DATE OF DEATH MONTH DAY YEAR 9 8 80		2b HOUR 12:10 A.M.
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 01 08 31		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD	
10 CITY OR TOWN OF DEATH Hampstead	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4004 Shiloh Avenue		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Line worker	12b KIND OF BUSINESS OR INDUSTRY B & D	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b CITY OR TOWN Hampstead	13c STREET ADDRESS 4004 Shiloh Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST Howard E. Caldwell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora L. Shenk			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-26-1490		17 INFORMANT ADDRESS Mrs. Loveric Herman, Manchester, Md.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Squamous Cell Carcinoma of Cervix 1809 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Obstructive Renal Failure					
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Aug 19 80 to 9/8 1980 that (I) (we) lost saw the deceased alive on 9/4 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.					
22b SIGNATURE Davis M. Hahn		DEGREE MD		22c DATE SIGNED 9/8/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Davis M. Hahn		22e ADDRESS 5801 Loch Raven Blvd 21239			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9-10-80		23c NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	
24 FUNERAL DIRECTOR NAME Elite Funeral Home, Hampstead, Md.		ADDRESS 21074		25 DATE REC'D BY REGISTRAR SEP 15 1980	
23d LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.		26 SIGNATURE OF REGISTRAR Kathy McHenry			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



•

GRIFFIN

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>Kenneth</b></span> <span>Middle <b>Leonard</b></span> <span>Last <b>Engleke</b></span> </div>			2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> <span>Month <b>09</b></span> <span>Day <b>07</b></span> <span>Year <b>80</b></span> </div>			2b. HOUR <b>9 A M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>5-15-21</b>		6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield Hospital Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7935 Dalrose Avenue</b>		
14. FATHER'S NAME First <b>August</b> Middle <b></b> Last <b>Engleke</b>			15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b></b> Last <b>Pflieder</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-12-3457</b>			17. INFORMANT Address <b>Records, Springfield Hospital Center</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion-myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration pneumonitis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs/min. <b>years</b> <b>day</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-14-58</b> , 19 <b>80</b> , to <b>09-07</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>09-07</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Suha Ozgun, M. D.</b>						DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>9-8-80</b>		
22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun, M. D.</b>						22e. ADDRESS <b>Springfield Hospital Center Sykesville, MD 21784</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>9/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR <b>John Wark 1211 Chesaco Ave.</b>						25a. REGISTRAR DATE <b>SEP 10 1980</b>			25b. REGISTRAR'S SIGNATURE <i>notary McBray</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

County of \_\_\_\_\_

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) EVA m. Gobrecht			2a DATE OF DEATH MONTH DAY YEAR 9-28-1980			2b HOUR 5:45 PM						
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 8 3 1900		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7 UNDER YEAR MONTHS DAYS HOURS MIN.				
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		9a CITIZEN OF WHAT COUNTRY? U.S.		9b MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD						
10 CITY OR TOWN OF DEATH Manchester		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Secretary		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE md.			13b COUNTY BALTIMORE		13c CITY OR TOWN Reisterstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 58 PENDRAGON CT.			
14 FATHER'S NAME FIRST MIDDLE LAST Samuel B. Gobrecht				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolly Blackburn								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO 171-07-1402		17 INFORMANT MARGARET Gobrecht				ADDRESS Reisterstown, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac arrhythmia 436- DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Cerebral Vascular Accident @ Diabetes mellitus												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (1) this hospital attended the deceased from 1/21/78, 19 to 9/28/80, 19 that (2) we last saw the deceased alive on 9/28/80, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)												
22b SIGNATURE W. F. Ford MD						DEGREE MD			22c DATE SIGNED 9/28/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) W. F. Ford MD						22e ADDRESS 3223 Main St Manchester, Md 21102						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 9/29/80		23c NAME OF CEMETERY OR CREMATORY West View Park			23d LOCATION CITY TOWN COUNTY STATE Baltimore, Md.				
24 FUNERAL DIRECTOR Eline Funeral Home Reisterstown, Md. 21136						25a DATE REC'D. BY REGISTRAR OCT 1 1980			25b REGISTRAR'S SIGNATURE R. J. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22b signature of both with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised.



*Handwritten signature*

1980

THE UNIVERSITY OF CHICAGO



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3 3 6 2  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <span style="margin-left: 100px;">First</span> <span style="margin-left: 100px;">Middle</span> <span style="margin-left: 100px;">Last</span> <span style="margin-left: 100px;">William</span> <span style="margin-left: 100px;">Vicktor</span> <span style="margin-left: 100px;">Greenstein</span>			2a. DATE OF DEATH Month <span style="margin-left: 20px;">Day</span> <span style="margin-left: 20px;">Year</span> <span style="margin-left: 20px;">September</span> <span style="margin-left: 20px;">6</span> <span style="margin-left: 20px;">1980</span>			2b. HOUR <span style="margin-left: 20px;">6:30</span> PM	
3. SEX <span style="margin-left: 20px;">Male</span>		4. RACE <span style="margin-left: 20px;">White</span>		5. DATE OF BIRTH <span style="margin-left: 20px;">12-10-<del>09</del></span> <span style="margin-left: 20px;">XX</span> <span style="margin-left: 20px;">08</span> <span style="margin-left: 20px;">19</span> <span style="margin-left: 20px;">71</span> YRS		6. AGE (In years last birthday) IF UNDER 1 YEAR MONTHS <span style="margin-left: 20px;">DAYS</span> IF UNDER 24 HRS HOURS <span style="margin-left: 20px;">MIN.</span>	
7a. BIRTHPLACE (State or foreign country) <span style="margin-left: 20px;">Maryland</span>		7b. CITIZEN OF WHAT COUNTRY? <span style="margin-left: 20px;">USA</span>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <span style="margin-left: 20px;">Carroll</span> COUNTY Md.	
10. CITY OR TOWN OF DEATH <span style="margin-left: 20px;">Sykesville</span>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <span style="margin-left: 20px;">Springfield Hospital</span>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <span style="margin-left: 20px;">PAINTER</span>		12b. KIND OF BUSINESS OR INDUSTRY <span style="margin-left: 20px;">SIGNS</span>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <span style="margin-left: 20px;">Maryland</span>		13b. COUNTY <span style="margin-left: 20px;">Baltimore</span>		13c. CITY OR TOWN <span style="margin-left: 20px;">Baltimore</span>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <span style="margin-left: 20px;">Middle</span> <span style="margin-left: 20px;">Last</span> <span style="margin-left: 20px;">Jacob</span> <span style="margin-left: 20px;">-</span> <span style="margin-left: 20px;">Greenstein</span>		15. MOTHER'S MAIDEN NAME First <span style="margin-left: 20px;">Middle</span> <span style="margin-left: 20px;">Last</span> <span style="margin-left: 20px;">Pearl</span> <span style="margin-left: 20px;">Goldscheider</span>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give date of discharge) (If yes give war or dates of service) <span style="margin-left: 20px;">NO</span>		16b. SOCIAL SECURITY NO. <span style="margin-left: 20px;">215-80-3926</span>	
17. INFORMANT <span style="margin-left: 20px;">MRS. EVA SOLOMON</span>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 20px;">Myocardial infarction</span> DUE TO, OR AS A CONSEQUENCE OF (b) <span style="margin-left: 20px;">Atherosclerosis or lung emboli</span> DUE TO, OR AS A CONSEQUENCE OF (c) <span style="margin-left: 20px;">Pulmonary carcinoma</span> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <span style="margin-left: 20px;">as above</span>		3010 ROMARIC CT. #21209		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="margin-left: 20px;">185-2 months</span> <span style="margin-left: 20px;">185-2 months</span>	
19a. DATE OF OPERATION <span style="margin-left: 20px;">6-10-1980</span>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="margin-left: 20px;">Carcinoma of the prostate</span>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <span style="margin-left: 20px;">Month</span> <span style="margin-left: 20px;">Day</span> <span style="margin-left: 20px;">Year</span> <span style="margin-left: 20px;">P.M.</span> <span style="margin-left: 20px;">19</span>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <span style="margin-left: 20px;">City or Town</span> <span style="margin-left: 20px;">County</span> <span style="margin-left: 20px;">State</span>			
22a. I certify that (this hospital) attended the deceased from <span style="margin-left: 20px;">9-11</span> , 1948 to <span style="margin-left: 20px;">9-5</span> , 1980, that (my) saw the deceased alive on <span style="margin-left: 20px;">9-6</span> , 1980, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <span style="margin-left: 20px;">S. ESENDA</span>		22c. PHYSICIAN'S NAME (Type) <span style="margin-left: 20px;">S. ESENDA</span>		22d. ADDRESS <span style="margin-left: 20px;">Springfield Hosp Center</span>		22e. DATE SIGNED <span style="margin-left: 20px;">9-6-1980</span>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="margin-left: 20px;">BURIAL</span>		23b. DATE <span style="margin-left: 20px;">SEPT. 9, 1980</span>		23c. NAME OF CEMETERY OR CREMATORY <span style="margin-left: 20px;">BALTIMORE HEBREW</span>		23d. LOCATION (City or Town) (County) (State) <span style="margin-left: 20px;">BALTIMORE</span> <span style="margin-left: 20px;">MARYLAND</span>	
24. FUNERAL DIRECTOR <span style="margin-left: 20px;">SOL LEVINSON &amp; BROS., INC.</span>		25a. REC'D BY REGISTRAR <span style="margin-left: 20px;">SEP 11 1980</span>		25b. REGISTRAR'S SIGNATURE <span style="margin-left: 20px;">[Signature]</span>		25c. ADDRESS <span style="margin-left: 20px;">6010 REISTERSTOWN RD. BALTO., MD 21215</span>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 6 3

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward W. Hand			2a DATE OF DEATH MONTH DAY YEAR 9-16-80			2b HOUR 1511 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.	
10 CITY OR TOWN OF DEATH Westminster		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Hospt.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman	
12b KIND OF BUSINESS OR INDUSTRY Paper		13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Carroll		13c CITY OR TOWN Hampstead	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1004 Scarlet Oak Ct.		14 FATHER'S NAME FIRST MIDDLE LAST Francis B. Hand		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella N. Steibbach	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17 INFORMANT ADDRESS Mrs. Edward Hand Hampstead, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mesenteric Vasculature insufficiency and digitoxicity</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Mesenteric Vasculature insufficiency and digitoxicity</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>9-10-1980</u> , to <u>9-16-1980</u> , that (I) (we) last saw the deceased alive on <u>9-16-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Chitra Chedou Nagananna</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDOU NAGANNA				22e ADDRESS 174 E. Main St. Westminster MD 21157			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Sept 17, 80		23c NAME OF CEMETERY OR CREMATORY Westview Memorial park		23d LOCATION Baltimore, Md. COUNTY STATE	
24 FUNERAL DIRECTOR NAME Eline Funeral Home Hampstead, Md. ADDRESS				25a DATE REC'D. BY REGISTRAR SEP 22 1980		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON AVE., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

321  
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										6023364	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Bernard Bradley Hartman						2a. DATE KNOWN OF DEATH 9-21-80		2b. HOUR 8:47 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 3-1908		6. AGE (IN YEARS) 71 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			
7c. DATE PRONOUNCED DEAD 9-21-80		7d. HOUR 8:47 AM		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Springfield Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofers		12b. KIND OF BUSINESS OR INDUSTRY Roofing			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 302 East Third Street			
14. FATHER'S NAME John Michael Hartman				15. MOTHER'S MAIDEN NAME Mary Catherine Leberherz				16. IF DECEASED EVER IN U.S. ARMED FORCES? Yes			
16a. SOCIAL SECURITY NO. unknown				17. INFORMANT Charles F. Hartman, Frederick, Md. 21701				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept 24, 1980		23c. NAME OF CEMETERY OR CREMATORY St. John Cemetery		23d. LOCATION Frederick, Frederick, Maryland			
24. FUNERAL DIRECTOR Smith, Fadelley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701				25a. DATE REC'D. BY REGISTRAR SEP 23 1980		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL/CLINIC ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 23365

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CHARLES EDGAR HOFF, SR.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Sept 9, 1980</b>		2b HOUR <b>1355 M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>April 3, 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>82 5 6</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>	
10 CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer-retired</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>Maryland</b>			13b COUNTY <b>Carroll</b>	13c CITY OR TOWN <b>Westminster</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Francis M. Hoff</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada C. Arnold</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>219-12-0282</b>		17 INFORMANT ADDRESS <b>1206 Frizzell Rd.</b> <b>Ruth H. Buckingham, Westminster, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Refractory heart failure</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A SCD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Generalized atherosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>COPD</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>May 4, 1980</b> to <b>Sept 9, 1980</b> , that (I) (we) last saw the deceased alive on <b>Sept 9, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>John S. Harshey, MD</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/9/80</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN S. HARSHEY, MD</b>			22e ADDRESS <b>8 Archer St. Westminster, Md. 21157</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9-13-1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Providence</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Gamber, Carroll, Md.</b>		24 FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr., Sykesville, Md.</b>			
25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE <b>SEP 15 1980</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3 3 6 6

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First Middle Last <b>Pauline Loretta Piper Hoy</b>			2a. DATE OF DEATH Month <b>9</b> Day <b>11</b> Year <b>80</b>			2b. HOUR <b>3:05P</b>					
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>04-06-14</b>			6. AGE (In years last day) <b>66</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll County,</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville, Maryland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield Hospital Ctr.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Welder</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>1404 Union Avenue</b>		
14. FATHER'S NAME First Middle Last <b>Arthur Piper</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Esther Crabbe</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <b>219-16-3196</b>			17. INFORMANT <b>Springfield Hospital Center Records</b>			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of cervix and upper vagina</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
												<b>weeks</b>		
												<b>year</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-24</b> , 19 <b>79</b> , to <b>9-11</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9-11</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <i>Suha Ozgun, M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>9-11-80</b>					
22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun, M.D.</b>						22e. ADDRESS <b>Springfield Hospital Center Sykesville, Maryland 21784</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9/15/80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Winters Church Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>New Windsor Carroll MD</b>					
24. FUNERAL DIRECTOR <b>Burgee Funeral Home 3631 Falls Road 21211</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 16 1980</b>			25b. REGISTRAR'S SIGNATURE <i>L. H. Brady</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1368



TO HOSPITAL ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles W. Hubbard			2a. DATE OF DEATH MONTH DAY YEAR Septem ber 3, 1980		2b. HOUR 1:00 <sup>P</sup> <sub>M</sub>	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1919		
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.						
13. CITY OR TOWN OF DEATH Finksburg		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2876 Lawndale Rd.		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier		
16. KIND OF BUSINESS OR INDUSTRY Post Office		17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Carroll Finksburg				
18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS 2876 Lawndale Rd. 21048				
20. FATHER'S NAME FIRST MIDDLE LAST William Hubbard			21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Over			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		23. SOCIAL SECURITY NO. WW II 218-01-8996		24. INFORMANT ADDRESS Evangeline Hubbard, wife, same address		
25. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CANCER OF LUNG - 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH May 1980						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE		
35. I certify that (this hospital) attended the deceased from May 5, 1980, to 8/14, 1980, that (we) lost saw the deceased alive on 8/14, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
36. SIGNATURE Seymour Weiner MD				37. DATE SIGNED 9/3/80		
38. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Seymour Weiner				39. ADDRESS 1900 E. Northern Parkway		
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE 9/6/80		42. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		
43. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		44. DATE REC'D. BY REGISTRAR SEP 5 1980				
45. FUNERAL DIRECTOR Stanimurek Funeral Home, Inc.				46. REGISTRAR'S SIGNATURE R. J. K. K. K.		

*Handwritten signature*

SEP 2 1980

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8 0 2 3 3 6 8	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Thomas H. Johnson		2a DATE OF DEATH MONTH DAY YEAR 7 1 80 2b HOUR 08 56 M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1909	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		6b CITIZEN OF WHAT COUNTRY? U.S.A.		6c AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		7c BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian	
13a STATE Md.		13b CITY OR TOWN Gylndon		13c STREET ADDRESS Insullin Lane	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Johnson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Parker		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b SOCIAL SECURITY NO 217-09-2654		17 INFORMANT Ida M. Johnson		18 ADDRESS 3726 Hayward Ave. Baltimore, Maryland 21215	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA 4039 DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOULAR NEPHROSCLEROSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebral Thrombosis Gram Negative Sepsis					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 8/22, 1980, to 9/1, 1980, that (1) (we) last saw the deceased alive on 9/1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23a SIGNATURE Vincent J. Fiocco Jr.		DEGREE MD		23c DATE SIGNED 9/1/86	
23b PHYSICIAN'S NAME (TYPE OR PRINT) Vincent J. Fiocco Jr.		23c ADDRESS Westminster, Md.		23d DATE REC'D. BY REGISTRAR SEP 8 1980	
23e BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23f DATE Sept. 4, 1980		23g NAME OF CEMETERY OR CREMATORY Lukes Cemetery	
23h LOCATION CITY OR TOWN COUNTY STATE Reisterstown, Balto., Md.		23i DATE REC'D. BY REGISTRAR SEP 8 1980		23j REGISTRAR'S SIGNATURE	
24 FUNERAL DIRECTOR NAME H. E. Ehlhardt		24b ADDRESS Owings Mills, Md.		24c DATE REC'D. BY REGISTRAR SEP 8 1980	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 6 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Minerva Dale Lechliter</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Sept 21 1980</b>		2b HOUR <b>0110 M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Apr. 10, 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>68</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD	
10 CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. Gen. Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Ind</b> 13b CITY OR TOWN <b>Balto.</b> 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d STREET ADDRESS <b>15 Stocksdale Ave</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lemuel P. Bean</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah W. Pope</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>216-18-1821</b>		17 INFORMANT ADDRESS <b>DIANA Meekins 285. tollgate Rd. Owings Mills, Md.</b>	

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**Cardiogenic Shock**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**4140**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Atherosclerotic Heart Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Sept 15, 1980</b> to <b>Sept 21, 1980</b> , that (I) (we) last saw the deceased alive on <b>Sept 21, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>John S. Harshey, MD</b>				22c DATE SIGNED <b>9/21/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN S. HARSHEY MD</b>				22e ADDRESS <b>Sanchez St. Westminster, Md. 21157</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIAL) <b>BURIAL</b>	23b DATE <b>Sept. 23, 1980</b>	23c NAME OF CEMETERY OR CREMATORY <b>Reis. Meth. Ch. Cem</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown Balto Md.</b>
24 FUNERAL DIRECTOR NAME <b>H. J. Ebbhardt</b>		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE <b>SEP 24 1980</b> <b>Hofmeyr/Melroy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 7 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Charles L Loats			2a DATE OF DEATH MONTH DAY YEAR 9 29 80			2b HOUR 10:30 a.m.		
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 5 28 1911	6 AGE (IN YEARS LAST BIRTHDAY) 69		7b HOUR 10:30 a.m.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD					
10 CITY OR TOWN OF DEATH Hampstead, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4162 Black Rock Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b KIND OF BUSINESS OR INDUSTRY Band D			
13a STATE Md.		13b COUNTY Carroll	13c CITY OR TOWN Hampstead	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 4162 Black Rock Road			
14 FATHER'S NAME FIRST MIDDLE LAST HOWARD ? LOATS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia ? Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17 INFORMANT NAME ADDRESS Naomi Loats 4162 Black Rock Rd. Hampstead, Md. 21074		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
18 CAUSE OF DEATH PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage from Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF (c) 6 mo.							PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a DATE OF OPERATION 4-16-80		19b CONDITION FOR WHICH OPERATION WAS PERFORMED CA of Lung		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (this hospital) attended the deceased from 4-16-80, 19, to 9-29, 1980, that (we) last saw the deceased alive on 9-24, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.								
22b SIGNATURE M.C. Porterfield		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9-29-80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) M.C. PORTERFIELD		22e ADDRESS HAMPSTEAD, MD. 21074						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/2/80		23c NAME OF CEMETERY OR CREMATORY Woodlawn Bridge Cemetery		23d LOCATION Rippsville, COUNTY		
24 FUNERAL DIRECTOR NAME H. J. Eckhardt		ADDRESS Manassas, Md.						

BP



DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										80	23371	
1 - FOR STATE REGISTRAR										CERTIFICATE OF DEATH		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Charles I. Lorentson										9/30/80		M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		IF ELDERLY YEAR MONTH DAYS		IF ELDERLY 24 HRS. HOURS MIN.		
Male		White		1 7 1924		56						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Canada		USA				Carroll County MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville		6761 Slacks Road				Mold maker		Tool & Die Work				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
MD		Carroll		Sykesville				6761 Slacks Road				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Charles I. Lorentson, Sr.				Johana Jensen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
No		-		145-16-7548		Mrs. Minnie E. Lorentson 6761 Slacks Rd., Sykesville, MD 21784						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure												
DUE TO, OR AS A CONSEQUENCE OF (b) Terminal cancer - 2 yrs.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 79 to 9/23 19 80, that (I) (we) last saw the deceased alive on 9/23 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B. C. Phreda				DEGREE				22c. DATE SIGNED 10/2/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. C. THADA				22e. ADDRESS 5356 Reisterstown Rd.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		10/3/80		Loudon Park Cemetery		Baltimore City MD						
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, P.A. NAME ADDRESS 8728 Liberty Rd., Randallstown, MD 21133						25a. DATE REC'D. BY REGISTRAR OCT 3 1980						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 7 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Lillian F. Luckett</b>			2a DATE OF DEATH <b>Sept. 11, 1980</b>		2b HOUR <b>8:45 P.M.</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Oct. 10, 1890</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b>		10 CITY OR TOWN OF DEATH <b>Westminster</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Westminster Nursing &amp; Convalescent</b>		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS <b>10114 Hoff Lane</b>		
13b STATE <b>Md.</b>		13c CITY OR TOWN <b>Finksburg</b>		13d INSIDE CITY LIMITS? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		
14 FATHER'S NAME <b>Walter S. Maxwell</b>		15 MOTHER'S MAIDEN NAME <b>Mary M. Kennedy</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		
16b SOCIAL SECURITY NO. <b>212-07-4198</b>		17 INFORMANT <b>Mrs. Mary M. Trumpower</b>		ADDRESS <b>Westminster, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intermittent CV Disease -</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } (b) <b>Chronic brain syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (the hospital) attended the deceased from <b>1-14, 1959</b> to <b>9-11, 1980</b> , that (I) (we) lost saw the deceased alive on <b>9-11, 1980</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <b>C. E. McWilliams</b>		
22c DATE SIGNED <b>9-12-80</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. E. McWilliams</b>		22e ADDRESS <b>11904 Reisterstown Rd. Reisterstown, Md. 21136</b>		
23a BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b DATE <b>Sept. 15, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>Finksburg, Carroll Co. Md.</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>Eline Funeral Home Reisterstown, Md. 21136</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 15 1980</b>		
25b REGISTRAR'S SIGNATURE <b>R. J. McHenry</b>						

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

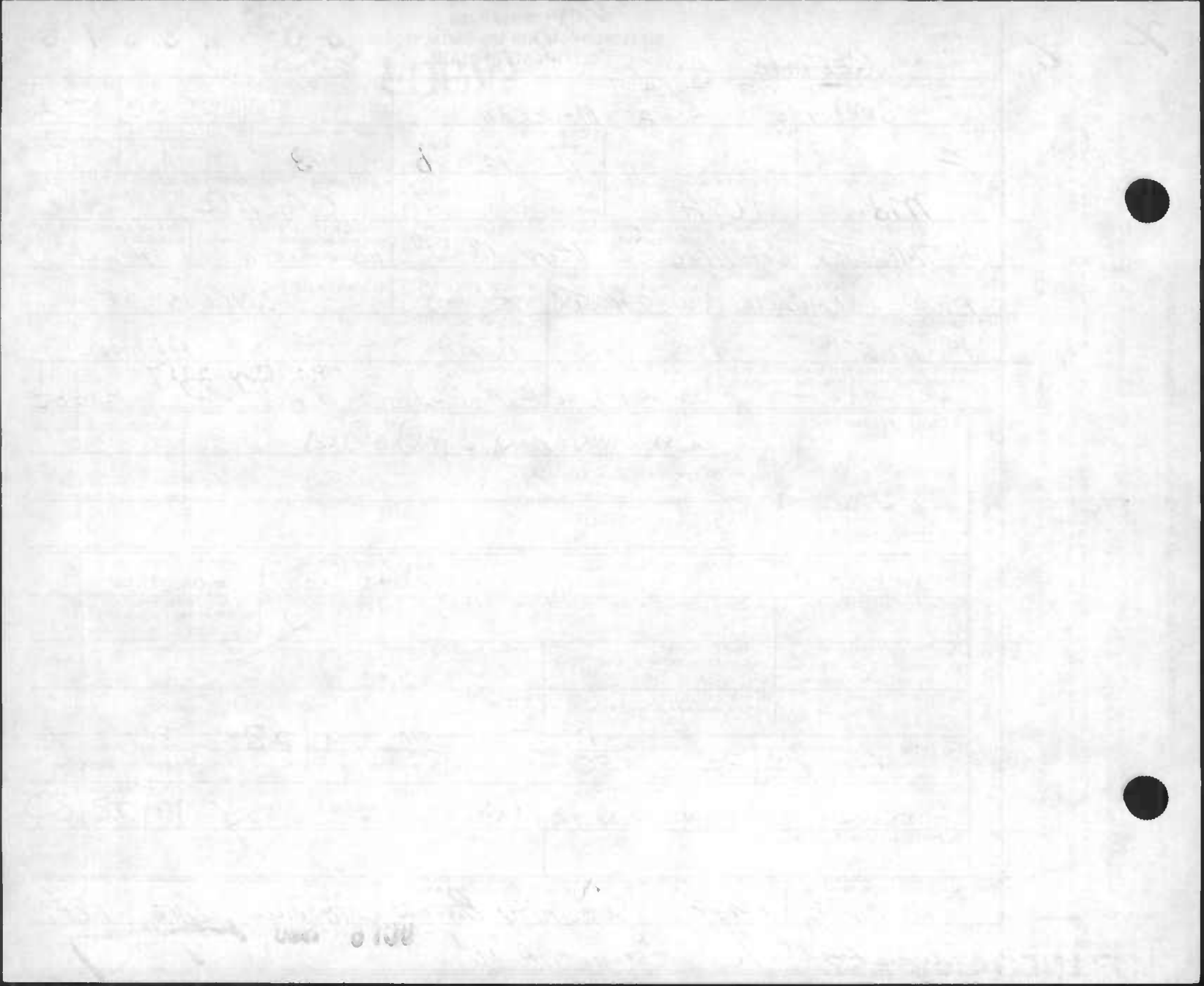
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 23373

1- FOR STATE REGISTRAR <i>Gertrude A</i>		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <i>Gertrude ANNA Mencken</i>		2a DATE OF DEATH MONTH DAY YEAR <i>09 28 80</i>	
3 SEX <i>F</i>		4 RACE <i>W</i>	
5 DATE OF BIRTH MONTH DAY YEAR <i>11 17 80</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>93</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i> MD	
10 CITY OR TOWN OF DEATH <i>WESTMINSTER</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CARROLL CO. GEN HOSP</i>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a STATE <i>Md.</i>		13b COUNTY <i>CARROLL</i>	
13c CITY OR TOWN <i>WESTMINSTER</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS <i>WILLIS ST -</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>August Mencken</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Abha</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b SOCIAL SECURITY NO. <i>220-44-0456</i>	
17 INFORMANT <i>H. Melendin</i>		ADDRESS <i>P.O. Box 2237 BALT. MD 21203</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>4151 Pulmonary embolus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO, OR AS A CONSEQUENCE OF (c).			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>coronary insufficiency congestive heart failure</i>			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/15 19 80</i>	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>7/15 19 80</i> to <i>9/28 19 80</i> , that (I) (we) lost saw the deceased alive on <i>9/28 19 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <i>[Signature]</i> M.D.		22c DATE SIGNED <i>9/28/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b DATE <i>10-1-80</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Security Process</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>CARROLL</i>	
24 FUNERAL DIRECTOR <i>[Signature]</i>		25a DATE RECEIVED BY REGISTRAR <i>9/16 1980</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 7 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Herbert Franklin Miller</i>			2a DATE OF DEATH MONTH DAY YEAR <i>Sept 21, 1980</i>			2b HOUR <i>0935 M</i>			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Sept. 23 1908</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS		7 UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD			
10 CITY OR TOWN OF DEATH <i>Westminster</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hospital, Store Owners</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Appliance</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Maryland</i>		13b COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Manchester</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>3177 Main St</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Wesley C Miller</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Cora Virginia Holtzman</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-22-5876</i>		17 INFORMANT ADDRESS <i>Phillip Miller, Manchester, Ind.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> 4140 DUE TO, OR AS A CONSEQUENCE OF b) <i>Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a) <i>aspiration pneumonia. Carcinoma of the colon</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>Sept 15, 1980</i> to <i>Sept 21, 1980</i> , that (I) (we) last saw the deceased alive on <i>Sept 21, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>John S. Harshey, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED <i>9/21/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN S. HARSHEY, M.D.</i>				22e ADDRESS <i>8 Ancker St. Westminster, Md. 21157</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>9/24/80</i>		23c NAME OF CEMETERY OR CREMATORY <i>Greenmount Em.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Westminster, Carroll, Md.</i>			
24 FUNERAL DIRECTOR NAME <i>H. J. Eckhardt</i>				ADDRESS <i>Manchester, Ind.</i>		25a DATE RECEIVED BY REGISTRAR <i>SEP 25 1980</i>			



OFFICIAL  
RECEIVED  
JAN 10 1964

LIBRARY OF CONGRESS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(FVR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTI. MATED		MONTH	DAY	YEAR	2b HOUR	
William Oscar Null		William	Oscar	Null	9 6 19 80		9	6	19	80	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	
Male	White	JAN 9 1947	73 YRS.			9 6 19 80				5:45 P.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				Carroll County MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Westminster		3920 Littlestown Pike				CABINET FACTORY CABINETS		PIKE			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
MD.		CARROLL		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3920 LITTLESTOWN PIKE			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
WILLIAM		NULL		MARGARET HOSFIELD							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
NO		216-14-5635		BEAVER		RED LION, PA 407 W. BROADWAY 17354					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head</u> 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9 6 19 80		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f LOCATION STREET CITY OR TOWN COUNTY STATE 3920 Littlestown Pike, Westminster, Carroll Co., Md.							
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant		DATE SIGNED			9-7-80				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Margarita A. Korell, M.D.		111 Penn Street									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		SEPT. 9, 1980		BACHMANN VALLEY		WESTMINSTER MD		CARROLL			
24 FUNERAL DIRECTOR NAME		ADDRESS		15a DATE REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE					
Richard Lueck		34 Monrovia		PA.		SEP 11 1980					

17340

000 11932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 23376 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JUANITA ✓ Russell</b>						2a DATE OF DEATH MONTH DAY YEAR <b>9 2 80</b>				2b HOUR <b>0203 M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 23 14</b>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS <b>66</b>		7a IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7b IF UNDER 24 HRS HOURS MIN <b>00</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL MD</b>					
10 CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL CO. GEN HOSP SUPERVISOR</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BANK</b>		12b KIND OF BUSINESS OR INDUSTRY <b>BANK</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>		13b COUNTY <b>CARROLL</b>		13c CITY OR TOWN <b>WESTMINSTER</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>1778 BALT BLV.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>LUTHER MYRTLE</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ARDENNA GREAVES</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>				16b SOCIAL SECURITY NO <b>215-05-4489</b>		17 INFORMANT <b>WALTER Russell</b>		17 ADDRESS <b>S/A</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>4140 RENAL FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b). <b>CONGESTIVE HEART FAILURE, INTRACTABLE WEEKS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c). <b>ATHEROSCLEROTIC CORONARY HEART DISEASE YEARS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>8/2 1980</b> to <b>8/2 1980</b> , that (I) (we) last saw the deceased alive on <b>9/1 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE DEGREE <b>Charles Johnson Jr MD</b>								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/2/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)								22e ADDRESS			
23a BURIAL CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>9/5/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>MEADOW BURY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>WESTMINSTER CARROLL MD</b>			
24 FUNERAL DIRECTOR NAME <b>R. H. Butts Jr</b>				ADDRESS <b>91 WILLIS ST, WESTMINSTER</b>		25a DATE REC'D BY REGISTRAR <b>SEP 11 1980</b>		25b REGISTRAR'S SIGNATURE <b>notary</b>			

1. *Phragmites* (Common Reed)



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMM-17

[VR A15 ME (5)]

15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23377	
1. DECEASED NAME (TYPE OR PRINT) William Charles			2b. DATE KNOWN OF DEATH MONTH DAY YEAR 9 6 1980			2c. DATE OF ESTI. MATED MONTH DAY YEAR 9 6 1980			2d. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 6 1980		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 / 23 / 1917		6. AGE (IN YEARS) 63 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7b. HOUR 8:45 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.		
10. CITY OR TOWN OF DEATH Westminister			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing agent			12b. KIND OF BUSINESS OR INDUSTRY Education		
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Timonium			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Elias Seebode			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Loretta Krout			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND FOR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 218-07-2039		
17. INFORMANT Mrs. Thelma M. Schnepfe			18. ADDRESS Timonium, Md. 1811 Reuter Rd.			19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic degenerative Cardiovascular Disease</u> 429.2 } DUE TO, (b) <u>Complicated by</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Severe Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs 4 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I had charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Richard A. Jones MD			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER Carroll County General Hosp,			DATE SIGNED 25 Sept 80		
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones MD			ADDRESS Westminister Md.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/10/80		
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.			23d. LOCATION Baltimore City, Maryland			24. FUNERAL DIRECTOR NAME Martin D. Lawson, 10 W. Padonia Road, Timonium			25a. DATE REC'D. BY REGISTRAR SEP 9 1980		
25b. REGISTRAR'S SIGNATURE R. J. Helms											

SEP 2 1980

Dr. C. A. Jones MD

Dr. C. A. Jones MD  
1000 1st St. N.E.  
Atlanta, GA 30309

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Atlanta, GA 30309

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Atlanta, GA 30309

Dr. C. A. Jones MD  
1000 1st St. N.E.  
Atlanta, GA 30309

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23373	
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>VERNON TILLMAN SPRIGGS JR.</b>			2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>			2b. HOUR <input type="checkbox"/>		
3. SEX <b>MALE</b>			4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		6. AGE (IN YEARS) LAST BIRTHDAY <input type="checkbox"/> YRS.		7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.		
10. CITY OR TOWN OF DEATH <b>SYKESVILLE</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SPRINGFIELD HOSP CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAINTER</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>VERNON</b> MIDDLE <b>SPRIGGS</b> LAST <b>SR.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>JOCILLE</b> MIDDLE <b>JONES</b> LAST <b>JONES</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>214-14-1129</b>		
17. INFORMANT ADDRESS <b>823 White/ock Street</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC ARREST</b> 4293 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>A.S.C.V.D.</b> (c) <b>5 YEARS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Daniel I. Welliver</b>			TITLE (SPECIFY) <b>ASST DEP</b>			MEDICAL EXAMINER			DATE SIGNED <b>9/28/80</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>DANIEL I. WELLIVER MD</b>			ADDRESS <b>218 WASHINGTON HEIGHTS WESTMINSTER MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/2/80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>MT HARBUR</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>W.C. BROWN COMM FH</b> ADDRESS <b>1206-08 W. North Ave</b>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>SEP 30 1980</b>					

(M)



DHAM 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	WALKLING		20. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
Ernest		Rosenberger		Walking			9 13 1980					23
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YEAR		7c. DATE PRONOUNCED DEAD		MONTH		DAY	YEAR
Male	White	October 29 1914		65	MONTHS		9 13 1980					23
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Westminster		U.S.A.				Carroll						MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Westminster		Residence 2139 Sykesville Rd.		McCormick Asbestos Co. Retired								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Westminster, Md.				21157
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. HOME ADDRESS				
Ernest		Eva		NO		213-03-6738		Eva Walking 2139 Sykesville Rd.				21157
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
4292												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I have charge of the remains described above. I hold an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										
Burial		Sept. 16, 1980		Deer Park Cemetery		Smallwood		Carroll				MD.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		Sept. 16, 1980		Deer Park Cemetery		Smallwood		Carroll				MD.
24. FUNERAL DIRECTOR		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Thomas D. Fletcher & Son F.H.		SEP 17 1980										
254 East Main Street												
Westminster, Md. 21157												

BP





82-11-200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

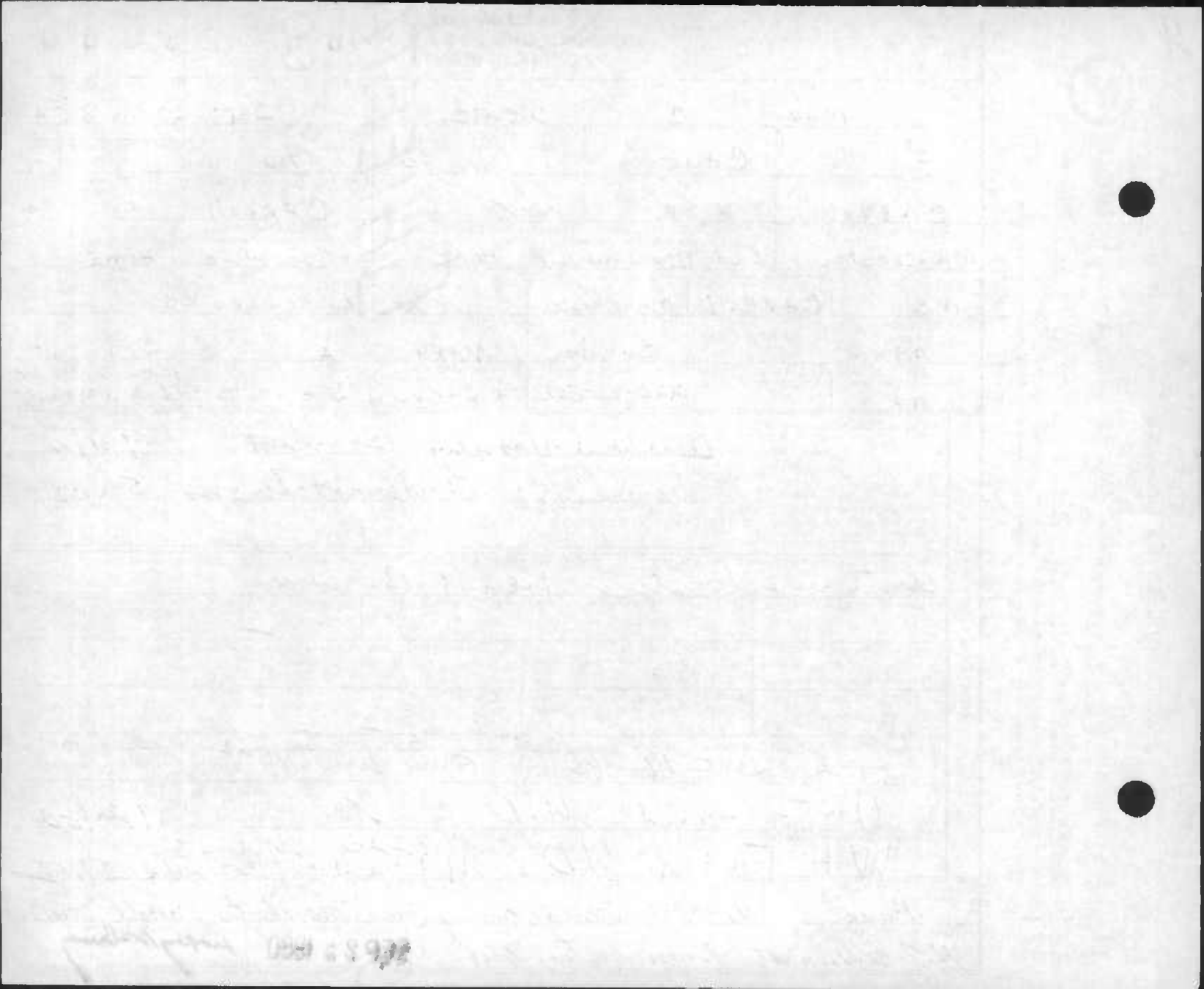
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 8 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE C. LAST WENTZ			2a DATE OF DEATH MONTH DAY YEAR Sept. 22 1980		2b HOUR 8:30 A.M.
3 SEX F	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR 1/11/90	6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7 IF DECEASED IN HOME MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CARROLL	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD		
10 CITY OR TOWN OF DEATH Manchester	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY HOME	
13a STATE md.	13b COUNTY CARROLL	13c CITY OR TOWN Manchester	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS Lineboro Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Adam Snyder		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A Schmidt			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-22-3073	17 INFORMANT ADDRESS Kathryn Sieverts - 1313 N MAIN ST. Manchester, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MON 5 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Sept 15 1980 to Sept 22 1980 that (I/we) last saw the deceased alive on Sept 19 1980 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we did) (did not view the body after death).					
22b SIGNATURE W H Foward M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/22/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W H Foward MD		22e ADDRESS 3223 Main St Manchester, Md. 21102			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 9/25/80	23c NAME OF CEMETERY OR CREMATORY New Lutheran Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.	
24 FUNERAL DIRECTOR NAME H. J. Eckhardt		ADDRESS Manchester, Md.		25a DATE REC'D. BY REGISTRAR SEP 25 1980	25b REGISTRAR'S SIGNATURE Kathryn Sieverts



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 3 8 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William M. Wilhelm			2a. DATE OF DEATH MONTH DAY YEAR Sept. 3 1980 7b. HOUR 4:15 M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Hampstead	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2130 Cape Horn Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter 12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William W. Wilhelm		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Krebs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Navy	17. INFORMANT ADDRESS Mrs. Darlene Wilhelm Hampstead, Md. (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF: b) DUE TO, OR AS A CONSEQUENCE OF: c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)				
19a. DATE OF OPERATION 5-15-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Lung		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 19 80 to 9-3 19 80, that (2) we last saw the deceased alive on 9-2-80 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (3) we did not view the body after death.				
22b. SIGNATURE M.C. Porterfield		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-3-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.C. PORTERFIELD		22e. ADDRESS 1114 J. MAIN ST., HAMPSTEAD, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Sept. 3, 80	23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. 21128
24. FUNERAL DIRECTOR NAME Eline Funeral Home		ADDRESS Hampstead, Md. 21074		25. DATE REC'D. BY REGISTRAR SEP 15 1980

REGISTRAR'S SIGNATURE



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>@LAIVE Elizabeth Wixon</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Sept 25, 1980</b>				2b HOUR <b>1010 AM</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>July 22, 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS <b>71</b>		8 IF UNDER 24 HRS HOURS MIN. <b>1010 AM</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Westminster</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. Gen. Hosp</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Dixie Cup</b>	
13a STATE <b>MD</b>		13b COUNTY <b>Carroll</b>	13c CITY OR TOWN <b>Hampstead</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>3927 Shiloh Ave</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Michael J. Bonner</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estella Klechner</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>174-10-6074</b>		17 INFORMANT <b>Paul E Wixon</b>		ADDRESS <b>3927 Shiloh Ave Hampstead, Md</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**496-**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **chronic obstructive lung disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**ASHD**

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>Aug 21, 1980</b> to <b>Sept 25, 1980</b> , that (I) (we) last saw the deceased alive on <b>Sept 25, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>John S. Harshbarger, MD</b>						22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN S. HARSHBARGER, MD</b>						22e ADDRESS <b>8 Archer St. Westminster, Md 21157</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b DATE <b>Sept. 27, 1980</b>	23c NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEM PARK</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>54 Kesville Carroll, Md</b>
24 FUNERAL DIRECTOR NAME <b>H. J. Eckhardt</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 29 1980</b>	
ADDRESS <b>Manchester, Md</b>		25b REGISTRAR'S SIGNATURE <b>notary/relaxing</b>	

